

NAVAL HOSPITAL
SAN DIEGO, CALIFORNIA

20-LCG:ame
3 October 1968

MEMORANDUM

From: CDR L. C. Getzen, MC, USN
To: Chief of Surgical Service

Subj: Resume of the Surgical Service over a Ten-Year Period, Fiscal Year 1959 through Fiscal Year 1968

1. Beginning in FY 1959, the Surgical Service encompassed Wards 26-1A, 1B, 1C, and 1D (General Surgery Enlisted); Plastic Surgery, Wards 26-2C and 2D; Proctology 26-5C and 4D; Dependents General Surgery, 26-5D; General Surgery, SOQ, 26-6D; Thoracic Surgery 26-5A and 5B; and Neurosurgery, 26-2A and 2B. In the interim, Thoracic Surgery, Neurosurgery, and Proctology have become separate Services under Department Heads. The following workload breakdown will be concerned primarily with that of the General Surgical Service, which today includes 26-1B and 1C (General Surgery Enlisted); Vascular Surgery; 26-5D, Dependents General Surgery; and 26-6D, General Surgery, SOQ. Plastic Surgery will be considered separately, as will Proctology, Thoracic, and Neurosurgery. In 1959, General Surgery was housed by Wards 26-1A, B, C, and D; 2-D; 4-D; 5-D; and 26-6D.

Primary Procedures pertained to a single operation for a single patient.

For FY's 1959 and 1960 the Outpatient Dependent General Surgical patients were seen in Building 38. There are no available statistics for this period of time. Also, during this interim, the admissions to the Dependent General Surgical Service were derived from Dependents Ward 26-5C and 5D rather than 26-5D only. Therefore, the Outpatient visits credited to the Surgical Service for this period are incorrect, but recorded as 3882 for Fiscal Year 1959 and 3920 for Fiscal Year 1960.

Graft #1 depicts the total Outpatient Visits, Admissions and Primary Surgical Procedures performed in the Operating Room by the General Surgical Service.

The Primary Surgical Procedures were accurately recorded for each surgical ward through the Chief of Surgical Service's office through FY 1961. Beginning FY 1962 the procedures were recorded through Data Processing for the entire Surgical Service, and there is a three year hiatus of recording procedures performed by each Service or ward (1962, 1963 and 1964) and the data for individual wards or Services was discontinued in the Chief of Surgery's office. Beginning FY 1965, these procedures were once again recorded by wards or Services in the Chief of Surgery's Office. For FY 1965 there were 2938 primary procedures performed by the General Surgery Service. During a four-year period, the primary procedures performed in the Main Operating Rooms by General Surgery, increased from 2938 to 3612, a 23% increase in the operative procedure load. It would appear that the operative load between FY 1959 through 1965 showed a small but definite decrease in volume. The significant increase has occurred in the past two Fiscal Years with the operative load going from 3048 to 3612, or an 18% increase.

The General Surgical admissions during this interim were 3729 for FY 1961 and 3113 for FY 1965. Again, through this period of time it would appear that the admission load showed a slight decrease. This decrease paralleled the minor decrease in operative procedures. During the interim, FY 1965 through FY 1968, there was a 63% increase in patient-admission load. The primary increase, occurring during the last two fiscal years, was from 3429 for FY 1966 to 5509 for FY 1968. In addition, there was a 22% increase in admissions to the Surgical Service during the past fiscal year, and 10% increase in operative load.

As previously mentioned, the outpatient recording for the Surgical Service was inaccurate during Fiscal Years 1959, 1960, and 1961. Beginning FY 1962 through FY 1968, the outpatient load showed an increase for 1962 through 1964. However, since FY 1964 the outpatient load has been relatively constant, showing a 5.6% increase during the past year.

In reference to the available bed capacity on the General Surgical Service, in FY's 1959 through 1962 the Vascular Surgery patients were treated on the Proctology Service. After 1962 these patients were treated on the General Surgical Service Ward bed areas; therefore, acquiring an added patient load from 26-4D. During this period of time, 26-4D functioned, in addition, as a "dirty-surgery" ward and the infected cases were admitted and treated on this ward. In March 1965, "dirty surgery-infected cases" were transferred to 26-1A. At this time the enlisted patients, who had previously been housed on 26-1A, were absorbed on 26-1B and 1C. The bed capacity for this area was lost to the enlisted General Surgical Service at large. However, certain infected cases remained on this ward and were treated by 26-1B and 1C personnel.

In 1961, 26-1D, which was an enlisted General Surgery Ward, was lost to the Service when a Pediatric Surgery Ward was created. Therefore, by FY 1966, 50% of the available beds for enlisted patients based on 26-1 deck were lost by the Surgical Service. In addition, certain infected cases and over-flow patients from the enlisted General Surgical Wards were housed on 26-2D, which was Plastic Surgery. In 1965 the Intensive Care Ward was created, at which time this area was lost. If one included the available ward space to the General Surgical Service at its inception in the 26 building, one could say that Wards 26-6D, 26-5D, 26-4C & D, 26-2C & D, 26-1A, B, C, & D were allotted. The patient load on 26-6D has shown a slow but progressive increase in patient load. Dependent General Surgery, on 26-5D, has remained relatively constant. Proctology has remained relatively constant; and Plastic Surgery has remained the same. Removing 26-6D, 5D, 4C and 2C, we have six available wards which were at one time used as enlisted General Surgery bed spaces. At the present time we now have only two wards, which is a 66% loss in bed space.

Figures 2 and 3 depict a breakdown in the Surgical Service ward or service workload, and as previously mentioned, the primary procedures were retrievable from these areas for FY's 1959, 1960 and 1961 and FY 1965 through FY 1968 through the Chief of Surgery's Office. This information is not available through the hospital statistics division of Patient Personnel or the Data Processing Service. The admissions during this interim reveal that there has been an average increase from 33 patients per month on SOQ to an average admission monthly rate of 46 for FY 1968. The admissions to Dependents, as previously mentioned for

FY's 1959 and 1960, are inaccurate because they cover both 26-5C and 5D. In 1961 there was an average monthly admission of 108 patients per month. Thereafter the admission rate has been relatively constant at approximately 85 admissions per month. The high admission load for 1961 resulted from the work that Captain Cronemiller was doing on Carcinoma of the Breast. For 26-1A & B, the admission rate for FY 1959 was 99 per month. Thereafter, it showed a progressive decrease until FY 1965 at which 26-1A acquired the "dirty surgery" admissions. The admission rate average per month then became 99 again. However, during the subsequent two years, the average monthly admission rate for 26-1A and 1B has risen to 182 admissions per month, with an average admission per month of 30 to 26-1A and 152 to 26-1B. During this same period of time, FY 1959-1968, 26-1C&D had an average admission of 90-99 for FY's 1959 and 1960. This admission rate showed a progressive decrease in spite of the loss of bed space in FY 1961 to an average patient load of 69 in FY 1965. Beginning in FY 1966 there has been a progressive increase to a load of 113 for FY 1968, or a 93% increase in patient load from FY 1965 through FY 1968. It is of particular interest that we have had a 93% increase in patient load with a 66% decrease in available space for housing these patients. If one interpolates this increase to available beds, it represents a 280% increase in patient load. The primary means through which this has been accomplished has been by rehabing herniotomies, postop gastrectomies, gallbladders, etc., within seven to ten days of their operative procedures, or when they were placed on a regular diet. Patients who require significant care are the only ones remaining on the wards. This could conceivably lead to potential complications. However, due to the excellent care afforded by the residents in observing these patients, our complications to date have been minimal under the present circumstances.

Figure 4 summarizes the General Surgical outpatient data and compares it to that of Plastic Surgery, Thoracic Surgery, and Neurosurgery.

Proctology has shown a progressive decrease in the patient admission load. This has resulted primarily through the acquiring of both Vascular and the infected cases by General Surgery Wards on 26-1B&C.

Figure 5 is a summary of the total operative procedures per month performed by the General Surgical Service. The void between FY's 1962 and 1965, as previously mentioned, resulted from the transmittal of Surgical data to the Data Processing System. The Data Processing System printed out a print-out in which the total procedures were performed rather than the total primary procedures. Beginning in FY 1966, the total primary procedures were printed out by Data Processing.

Figures 6 and 7 give a breakdown of the workload for Plastic, Proctology, Neurosurgery and Thoracic Surgery. This data was retrieved through the Chief of Surgery's office through FY 1967. Beginning FY 1968, Proctology, Thoracic Surgery and Neurosurgery became separate Services, and this data was no longer available. However, the data from Plastic Surgery is extended through FY 1968. It is of interest to note that the admissions to the Proctology Service have more or less paralleled the ancillary admissions of Vascular and infected cases, and the decrease in admission load to this Service is reflected by the loss of

the above cases to the General Surgery Wards on 26-1B and C. Neurosurgery showed a gradual and progressive decrease in admission load until FY 1967 at which point it showed a significant increase in the admission load which paralleled that of the General Surgery Service. Thoracic Surgery's admission load has remained relatively constant throughout a ten-year period, showing minor spikes of either increase or decrease. The present average monthly admission load is approximately 55 patients per month compared to 59 patients per month in FY 1959. The Outpatient workload for Proctology and Neurosurgery tended to parallel the Admission load. There was a slow but progressive increase in the outpatient work in Thoracic. The operative workload for Proctology, Neurosurgery, and Thoracic Surgery have remained relatively constant for the past four years. The workload for Plastic Surgery has tended to parallel that of Neurosurgery, showing a significant increase in the admission rate for FY's 1967 and 1968. However, the operative load has not increased significantly in the Main Operating Room. This is due primarily to the number of Plastic Surgery procedures which are performed in the Plastic Surgery Outpatient Clinic, on both in- and out-patients. Acquiring the primary operative procedure data from that obtained through the Chief of Surgery's office, it is of interest to note that Urology, ENT, Orthopedics, OB-GYN and the Eye Service have shown significant changes over the past four year period in that Orthopedics, ENT and Eye have shown a significant increase in their operative load, especially during the past two fiscal years, whereas Urology has remained relatively constant. OB has decreased in operative procedures and GYN has increased in operative procedures. The significant changes in ENT, OB-GYN and Eye are attributed primarily to changes in Chiefs of Services, whereas the change noted in Orthopedics is attributable to the same change which occurred on General Surgical Service - - an increased load from the Vietnamese campaign.

This is depicted in Figure 7.

Figure 8 is a summary of Figure 7 which shows that Thoracic, Proctology and Urology have remained essentially unchanged in their operative procedures during the past four fiscal years, whereas OB, Plastic and Neurosurgery have shown a decrease, and General Surgery, Orthopedics, ENT, Eye, and GYN have shown a significant increase in their operative procedures.

Figure 9 is a summation of the surgical procedures performed and recorded by Data Processing for FY's 1966, 1967 and 1968 compared to the operative load by the General Surgery Service. It will be noted that there are two void areas for totals of primary procedures. These are in fiscal years 1967 and 1968; the month of February is missing for 1967; the month of October for 1967. A summation and comparison of the data was then made for FY's 1965, 1966, 1967, 1968, for that obtained through the Data Retrieval by Mrs. Eaton and Miss Petter. It will be noted that there is a significant discrepancy between the actual total primary procedures and those recorded by Data Processing. In FY 1966 there was a small overlap and this was due to the feeding in of primary procedures done in ENT operating room. However, in March of 1966, procedures from the Orthopedic Clinic were then fed in. This was carried on through to the present. However, there is

a significant error noted in the data for the months of January, February and April of 1967, along with July, September, October, November and December of 1967. Two factors appeared to have been involved in these retrieval errors; one was that in December 1966 the transcribing of the operative reports was moved down to Central Dictation at which point the operative reports were inadequately screened by personnel who knew only the fundamentals of data recording and not the applied surgical operative terminology; and secondly, a loss of personnel who had a knowledge of surgical data recording. This latter was corrected in October 1967 when an individual was hired for this purpose. It required approximately three months for her to become adequately acquainted with the surgical data retrieval recording processes. In the interim, a severe load of unrecorded operative reports were acquired. These were recorded after the hiring of the present surgical data retrieval clerk. Since January 1968 this recording has been relatively accurate. However, if this one individual, who is a GS-3, resigns, we will find ourselves in a similar position that we were in the past. With respect to surgical data retrieval from the operative reports, this has been performed since November 1961. The hospital Main Operating Room Log has been constructed from the data retrieved. Therefore, because of the inaccurate submissions of the above-mentioned months, the Main Operating Room Log is incomplete for FY's 1966 and 1967.

Comparing the recorded total operative procedures for FY's 1966, 1967 and 1968 through Data Processing, the totals are 12,523, 12,562, and 11,351 respectively. The total primary procedures retrieved through the Chief of Surgery's office for FY's 1965, 1966, 1967 and 1968 are 9,889, 9,947, 10,542, and 11,054 respectively. The latter represents an overall accurate increase of 11% in total primary procedures.

From 1961 until the present, the Pediatric Surgery Ward has been under the supervision of the General Surgery Service, and for FY 1967 there were approximately 1700 admission to this ward, as compared to approximately 750 admissions to the primary Pediatric Service itself. From the available information, it would appear that this ratio has remained relatively constant during the past seven years. During this interim the officer-in-charge of the Dependents Surgery Section , 26-5D, was the designated officer-in-charge of 26-1D.

Table I-A is a Memorandum from the Chief of Surgical Service, Naval Hospital San Diego, to the Chief, Patient Affairs requesting data information over the ten-year period as previously reported. Table 2 is the data furnished through this above-mentioned request. Paragraph 1, a) b) and c) are the average totals for the entire hospital. It will be noted that data retrieval for the entire hospital is available only back to 1961; the Outpatient Admissions back to 1963; and the Primary Operative Procedures back only to 1965. Furthermore, the Outpatient visits by Services are available only from 1965 to the present, and the admissions for only the past two years. The Primary Surgical Procedures were available back to 1965. It is of particular interest to note that 100% of the data for the Outpatient Visits by Medical and Surgical Services, the primary surgical procedures and total admissions to the hospital per Service originate in Miss Petter's office. Secondly, taking the hospital's statistics at large, 100% of the data related to the primary operative procedures and the data related to total hospital admissions is compiled in Miss Petter's office.

NAVAL HOSPITAL
SAN DIEGO, CALIFORNIA

20-LCG:ame
30 September 1968

MEMORANDUM

From: Chief of Surgical Service
To: Chief, Patient Affairs

Subj: Statistics for Surgical Service

1. It is requested that the Statistical Section furnish me with the following information:

- a) Average outpatient visits per month per fiscal year for fiscal years 1958 through 1967.
- b) Average admission per month per fiscal year through the same period.
- c) Average primary surgical procedures performed per month per fiscal year 1958 through 1967 in the main operating rooms.
- d) The above information from the following services:
 1. General Surgery - 26-1B (A-B)
26-1C (C-D)
SOQ - 26-6D
Dependents - 26-5D
Vascular

2. Proctology
3. Plastic
4. Neurosurgery
5. Thoracic Surgery
6. Orthopedic Surgery
7. Urology
8. Otolaryngology
9. Ophthalmology

2. The above information is requested as soon as possible.



R. C. LANING

Table #1

I (d) 1 cont'd

Thoracic Surgery -	1965	150	Otolaryngology -	1965	1284
	1966	148		1966	1536
	1967	165		1967	1609
	1968	158		1968	1587
Orthopedic -	1965	1776	Ophthalmology -	1965	2723
	1966	1347		1966	2545
	1967	1500		1967	2839
	1968	1637		1968	2967
Urology -	1965	1624			
	1966	1560			
	1967	1515			
	1968	2049			

2. Average admissions per month per fiscal year:

General Surgery -	1967	339	Orthopedic -	1967	196
	1968	348		1968	216
Proctology -	1967	66	Urology -	1967	146
	1968	57		1968	165
Plastic -	1967	32	Otolaryngology -	1967	156
	1968	27		1968	149
Neuro-Surgery -	1967	76	Ophthalmology -	1967	58
	1968	79		1968	61
Thoracic Surgery-	1967	30			
	1968	35			

3. Average primary surgical procedures performed per month per fiscal year.

General Surgery -	1965	244	Neuro-Surgery -	1965	40
	1966	252		1966	45
	1967	266		1967	32
	1968	307		1968	30
Proctology -	1965	53	Thoracic Surg -	1965	36
	1966	43		1966	32
	1967	51		1967	33
	1968	41		1968	38
Plastic -	1965	42	Orthopedic -	1965	100
	1966	38		1966	96
	1967	33		1967	115
	1968	31		1968	130

13-GEF:lw

4 October 1968

MEMORANDUM

From: Chief, Patient Affairs Division

To: Chief of Surgical Service

Subj: Statistics for Surgical Service

Ref: (a) Chief of Surgery memo of 30 Sept 68

1. The following statistics are furnished as requested by reference (a). These include the earliest dates available.

(a) Average outpatient visits per month per fiscal year:

1961 - 40568	1965 - 42477
1962 - 43370	1966 - 47748
1963 - 44693	1967 - 49481
1964 - 44595	1968 - 53295

(b) Average admissions per month per fiscal year:

1963 - 2342	1966 - 2380
1964 - 2362	1967 - 2314
1965 - 2267	1968 - 2323

(c) Average primary surgical procedures performed per month per fiscal year in the main operating room:

1965 - 825	1967 - 872
1966 - 831	1968 - 921

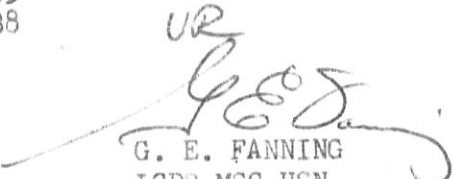
(d) The above information from the following services:

1. Average outpatient visits per month per fiscal year:

General Surgery -	1965	1065	Plastic -	1965	249
	1966	1152		1966	282
	1967	1206		1967	327
	1968	1313		1968	312
Proctology -	1965	271	Neuro-Surg -	1965	280
	1966	295		1966	334
	1967	266		1967	496
	1968	285		1968	604

I (d) 3 cont'd

Urology -	1965	90
	1966	79
	1967	81
	1968	93
Otolaryngology -	1965	25
	1966	32
	1967	39
	1968	41
Ophthalmology -	1965	25
	1966	45
	1967	43
	1968	38

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G. E. FANNING
LCDR MSC USN

Statistics furnished on the attached memo were compiled from copies of BUMED reports. Current instructions require these reports to be retained for a two year period only; therefore, statistics were not available prior to the dates shown thereon.



G. E. FANNING
Chief, Patient Affairs Division

Table 3 is a breakdown of the total admissions (admissions obtained through Data Processing plus TOW's to the ward, abstracted by Miss Petter) for FY 1966 and FY 1967 are noted in Column One. Column Two show the changes in primary operative procedure workload for FY's 1966, 1967 and 1968. Column Three is a compilation of Columns One and Two, which are an indirect reflection of the inpatient workload for the Services performing major surgical procedures at this hospital. Table 4 summarizes the work unit changes noted in the above Services. It is of particular interest that the overall workload for General Surgery during this period has increased 21%, Orthopedics 10%, whereas Urology has had a 4.3% decrease. These three Services represent the primary surgical operating services on active duty personnel.

Table 5 was taken from the statistics published by the Bureau of Medicine and Surgery for Fiscal Year 1966. Statistics for Fiscal Year 1967 are not available at this hospital, and for 1968 they have not been compiled. It is of particular interest to note that for Fiscal Year 1966 the General Surgical Service at this hospital admitted 1.5% of all patients admitted to Naval Hospitals throughout the Navy, and 11.9% of the patients admitted to the Naval Hospital, San Diego, California for Fiscal Year 1966. Furthermore, we equaled or surpassed eight of the 27 Naval Hospitals or Medical Centers in the U. S. Navy.

Of the 500 four-year programs in the Directory of Approved Internships and Residencies for Fiscal Year 1967 and Fiscal Year 1968, published by the AMA, there were only two hospitals, Cook County in Chicago and Baptist Hospital in Memphis, Tennessee in whom the average daily census and admissions were greater than those of the Naval Hospital, San Diego, California. For admissions to the Surgical Service during this interim, we surpassed by 1481 admissions our closest rival of all Army, Navy, Air Force and Public Health Hospitals.

The most interesting feature of the Surgical Service has been that the residents have been so efficient, especially on the enlisted wards and the Sick Officers Surgery Ward, where the clinic areas, Outpatient visits, and rehab patient sick calls have been effected through the able assistance of rehabs from the general rehab office. The second feature has been the tremendous adaptability of Marine Corps Sergeants and Corporals, Navy Bo's'n Mates, Electronic Technicians, Ships Cooks, Machinists, and an occasional Hospital Corpsman in becoming physician's assistants.

Table 6 is an outline of the jobs performed in the above mentioned areas as prepared by Chief Hospital Corpsman Couch, who was one of our recent rehab assistants on 26-1B. I would venture to say that this is the only teaching Service of the 500 hospitals noted with approved four-year residency programs in General Surgery where the Chief of Surgery does not have at least one full-time secretary.

It is of further interest to note that the two Surgical Services that treat active duty personnel, whom we have consistently surpassed in their admissions, i.e., Orthopedics and Urology, have a total of seven allotted orthopedic Cast Room Technicians and eleven Urology Technicians, a total of 18 enlisted

<u>CHANGE IN PATIENT ADMISSION LOAD</u> <u>FISCAL YEAR 1966 - 1967</u>	<u>CHANGE IN MOR PRIMARY PROCEDURE LOAD</u> <u>FISCAL YEAR 1966-1968</u>	<u>CHANGE IN PATIENT ADMISSIONS 1966-1967</u> <u>PLUS CHANGE IN PRIMARY PROCEDURES '66-67</u>
ENT (1393 to 1627) up by 234 or 16%	(374 to 492) up 118 or 31%	(1767 to 2119) up 352 or 20.5%
EYE (956 to 952) down by 4 or 0.4%	(540 to 456) down 84 or 15.5%	(1496 to 1408) down 88 or 5.2%
ORTHO (2392 to 2351) down by 41 or 1.6%	(1152 to 1548) up 396 or 25%	(3544 to 3899) up 355 or 10%
UROLOGY (2132 to 1842) down 290 or 13%	(960 to 1116) up 156 or 16%	(3092 to 2958) down 134 or 4.3%
THORACIC (870 to 660) down 210 or 25%	(410 to 456) up 46 or 11%	(1280 to 1116) down 164 or 12.8%
NEUROSURGERY (892 to 961) up 69 or 7.7%	(528 to 348) down 180 or 34%	(1420 to 1309) down 111 or 7.7%
OB-GYN (5912 to 6204) up 292 or 4.9%	(2004 to 2040) up 36 or 1.2%	(7916 to 8244) up 328 or 4.1%
PROCTOLOGY (588 to 647) up 59 or 10%	(560 to 508) down 52 or 9.3%	(1148 to 1155) up 7 or 0.6%
GENERAL SURGERY (3429 to 4236) up 807 or 23.8%	(3048 to 3612) up 564 or 18.5%	(6477 to 7848) up 1371 or 21%
PLASTIC SURGERY (288 to 610) up 322 or 112%	(456 to 372) down 84 or 18%	(744 to 982) up 238 or 32%

Table #3

FISCAL YEARS 1966, 1967, 1968

WORK UNITS INCREASES

PLASTIC SURGERY	32%
GENERAL SURGERY	21%
ENT	20.5%
ORTHOPEDICS	10%
OB-GYN	4.1%
PROCTOLOGY	0.6%

WORK UNITS DECREASES

THORACIC SURGERY	12.8%
NEUROSURGERY	7.7%
EYE	5.2%
UROLOGY	4.3%

STATISTICS OF NAVY MEDICINE

(Table H-1) Selected workload data for individual NAVAL HOSPITALS and MEDICAL CENTERS, ALL CATEGORIES OF PATIENTS FY 1966

<u>NAVAL HOSPITAL OR MEDICAL CENTER</u>	<u>ADMISSIONS FY 1966</u>
All naval hospitals	208,787
United States, total	194,859
Annapolis, Md.	1,629
Beaufort, S.C.	3,972
Bethesda, Md.	11,743
Bremerton, Wash.	3,254
Camp LeJeune, N.C.	9,890
Camp Pendleton, Calif.	10,321
Charleston, S. C.	9,302
Chelsea, Mass.	7,346
Corpus Christi, Tex.	3,447
Great Lakes, Ill.	11,796
Jacksonville, Fla.	8,548
Key West, Fla.	3,583
Memphis, Tenn.	4,713
Newport, R.I.	6,295
Oakland, Calif.	13,372
Pensacola, Fla.	5,779
Philadelphia, Pa.	12,754
Portsmouth, N.H.	2,572
Quantico, Va.	2,612
Portsmouth, Va.	20,298
St. Albans, N.Y.	10,829
San Diego, Calif.	28,883
NSMC New London, Conn	1,920
Outside US ashore, total	13,928
Guam, Marianas Isls.	4,563
Guantanamo Bay, Cuba	1,718
Subic Bay, Philippines	901
Yokosuka, Japan	6,746

NAVAL HOSPITAL
SAN DIEGO, CALIFORNIA

20-LCG:ame
30 September 1968

MEMORANDUM

JOB DESCRIPTION, Doctors' Offices - 26-1A&B and 26-1C (As filled by rehab patients since 1957)

1. Keep Wards B Admission and Discharge log (items most frequently needed)
 1. Date of Admission
 2. Does or does not have Health Record
 3. Date of dictation of Chart
 4. Disposition of Chart and Health Record
 5. Date of discharge or duty party
2. Maintain hospital charts on all "rehab" patients.
Place in chart all "chits" (blood, lab, x-ray, etc.)
When the Medical Officer orders a chart pulled for dictation, clean chart by pulling all blank pages and place all in numerical order by date. Place chart in Health Record and place on the Medical Officer's desk.
3. Maintain outpatient clinic log and organize rehab sick call and outpatient clinics to insure a smooth flow of patients.
4. Assist the Medical Officers in treating, change dressings, suture removal, etc., during sick call.
5. Keep the supply cabinets and treatment tables clean and stock with needed supplies and equipment.

1 attch #16

personnel to assist the staff and resident physicians in patient care. Furthermore, both of these Services have full-time secretaries. In addition, the General Surgery Service has surpassed the combined total admission and operative procedures of these two Services for the past three fiscal years. The General Surgical Service has surpassed the total primary operative procedure workload in the Main Operating Room of Thoracic Surgery, Neurosurgery, Orthopedics and Urology for the past three years. Utilizing the admission surgery workload for inpatient procedures and work output for patient discharge and operative report proceedings, we have surpassed these four Services during the past three years.

One wonders what methods have been used by Civilian Personnel and Staff Personnel to assign both military and civilian personnel in areas associated with patient care during the past ten years since it is quite evident that an analysis of the overall workload has not been used. If it had, the Chief of Surgery would have at least a full time secretary in his office who would supervise a secretary for the First Deck (Building 26) where the enlisted General Surgical patients are housed; a combined secretary for General Surgery Dependents and SOQ General Surgery; and a secretary for the Operating Room. In addition, adequate personnel would have been assigned to the areas where this tremendous workload has and does exist.

This report thus far has included only the clinical aspects of the Surgical Service. The Chief of Service is solely responsible for the smooth function of the Operating Room; the OR Technician School; the Central Supply area of this hospital; and one of three Tumor Boards housed by this hospital. With respect to Tumor Boards, it is of particular interest that this hospital annexed 1300 new Tumor Board cases during the proceeding fiscal year, which was one of the largest annexations noted by the Inspector when the Tumor Registry was recently reviewed. This tremendous service has been grossly understaffed.

Summary: During the past ten years, Dependent General Surgery has averaged approximately 85 admissions per month and has remained relatively constant. SOQ General Surgery has shown a slow but progressive rise in the admission load of an average of 33 admissions per month to that of 44 admissions per month. The enlisted general surgery area has shown a slow but progressive decline in admissions through FY 1965, at which point there was a marked increase in the admission load, resulting in a 93% increase.

There has been a 66% decrease in available bed space for the enlisted general surgery admissions during this interim. If one interpolates the present bed capacity as compared to the past, we have acquired a 280% increase in the patient load of 26-1 for general surgery patients.

There has been a progressive increase by the General Surgical Service in the Main Operating Room primary procedure workload during this interim, increasing from 2938 procedures in FY 1965 to 3612 for FY 1968, a 23% increase in workload. The primary increase has been that associated with the increase in admission load on the 1st deck of Building 26.

This tremendous workload has been accomplished primarily through the sincere efforts of the General Surgery Residents, with no significant corpsman assistance in the clinic areas. It is gratifying that during the past two years a permanently assigned corpswave has been on 26-5D and a corpsman has been assigned to the Vascular Surgery clinic.

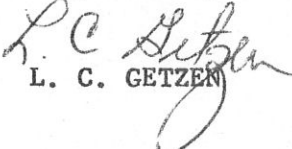
Probably one of the most remarkable feat has been the functioning of this really large General Surgery Teaching Program without a secretary assigned to the Surgical Service. Unfortunately, because of the lack of sufficient secretarial help in the Chief of Surgery's Office, it has been impossible to record the very fine presentations by the residents at the surgical conference (Med-Surg-GI Conference, Basic Science Conference, Morbidity-Mortality Conference, and the Saturday morning Surgical Conference).

The available surgical statistics presented were acquired and maintained through the efforts of Miss Petter, assisted by Mrs. Eaton. These statistics were accurately recorded for data processing while under the direct supervision of the Chief of Surgery's Office. However, with the removal of the processing of the operative reports to the Central Dictating area, this data became unreliable. Secondly, there was no significant surgical operative report "delinquent list" prior to the relocation of the transcriber-clerk-typists. Following the relocation of these civilians, a "delinquent list" has become an added workload to the residents and staff through redictating these reports.

Probably, one of the most regrettable feature of our program is that through the lack of assistance at the resident-level, it is almost impossible to report in medical journals the innumerable significant series we have accumulated in the past ten to twelve years at this hospital. We should be one of the leading lights in reporting surgical case series and unusual cases that have been encountered. However, because the residents have had to spend so much of their time personally preparing lists for retrieving charts, x-rays, laboratory data, dictating a tremendous volume of charts and operative reports, conference presentations, and the diligent handling of patients, it is almost impossible to accomplish any significant reporting of our workload. There are just not that many hours in the day.

If a Unit Citation could be given, it should be given to all of the residents who have gone through this program during the past ten years.

Respectfully submitted,


L. C. GETZEN